# Patient Information

**Date:** _____

How did you hear about us? ☐ Patient ☐ Physician ☐ Attorney ☐ Google ☐ Other_____

**Last** Name: _____ **First** Name: _____ Middle: _____

Address: _____ Apt/Lot# _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Birth Date: _____ Social Security# **XXX - XX -** _____

Email Address: _____

Employer: _____ Employer # _____

>>> Spouse's Name & #: _____

>>> -or- Emergency Contact Name & #: _____

Emergency Contact's relationship: Significant Other Parent Child Friend Other _____

Main Complaint: _____

_____

Date of Accident: _____ -or- Date of Symptom Onset: _____

Description of Accident: _____

_____

_____

_____

Have you consulted anyone else for this condition?

☐ YES ☐ NO

Physicians Name: _____

Location: _____

Allergies? _____

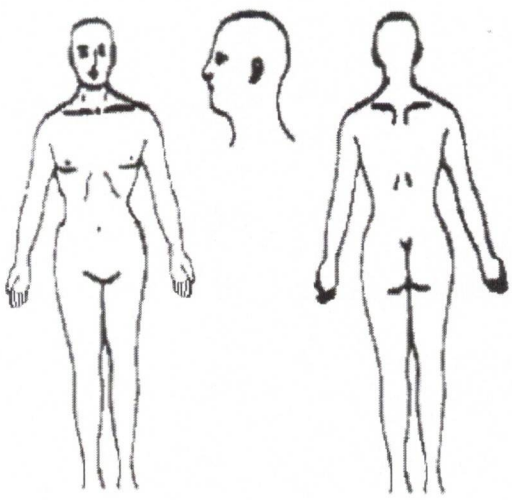
**Please Mark Pain Scale with an X**

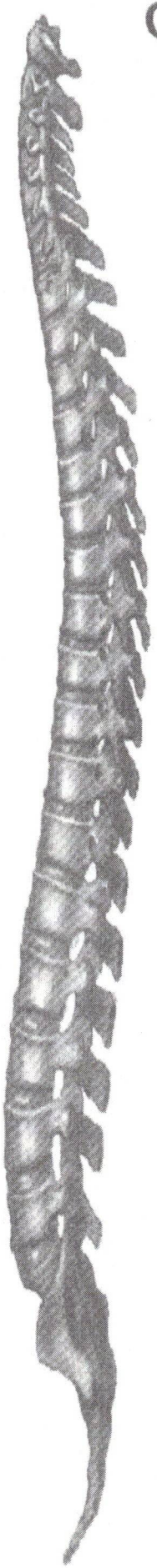
NO Pain Severe Pain

0 I I I 5 I I I 10

Method of Payment: ☐Cash-Check-Card ☐ Insurance

**Mark Areas: Pain = X Numbness = O**





# Gulfview Chiropractic & Wellness Center

## Dr. Charles Halley

Patient Name_____ Date of Birth _____

**General Consent to Treat**

I voluntarily consent to medical care of a routine/emergency nature form the authorized professional staff of Gulfview Chiropractic for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care. I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

**Financial Agreement**

I authorize payment of any medical benefits to Gulfview Chiropractic, which would otherwise be payable to me and which were established by my insurance company. The amount paid to Gulfview Chiropractic shall not exceed the practice's regular charges for the services. I also authorize the release of my medical records to my insurance company/companies or other third party payers or my employer as required for the collection of payments. I understand that I am responsible for the payment of charges that are not paid by my insurance company.

**Payment Agreement**

I understand this office requests that I read my insurance policy and be fully aware of any limitations of the benefits provided. I understand that my insurance policy is between me and the insurance company. Although they will gladly help, it is my responsibility to know the limitations of my policy. I understand that any charge incurred beyond the reimbursement of said policy will be my financial responsibility.

**HIPAA**

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

I have read the above and understand my financial obligation.

Patient Signature_____Date_____

Spouse/Guarantor Signature/Relationship_____

Witness _____ Date_____

# Gulfview Chiropractic and Wellness

In accordance to HIPAA practices, I authorize my medical information to be released to the following person(s):

___ NO other person

☐ Spouse_____

☐ Doctor_____

☐ Doctor_____

☐ Child_____

☐ Child_____

☐ Child_____

☐ Child_____

☐ Other_____

☐ Other_____

☐ Other_____

_____ _____

Signature Print Name

_____

Date

# Gulfview Chiropractic & Wellness Center

## ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Dr. Charles Halley / Gulfview Chiropractic** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements and,
(3) to institute any necessary litigation and/or complaints against my insurance policy, naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian if the patient is a minor).

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

**A photocopy of this form shall be considered as effective and valid as the original.**

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's signature Date

8323 US 19, Port Richey FL 34668 Phone: 727-847-4611 Fax: 727-842-3524

# Patient Request for Records

**I hereby authorize the release copies of my records and x-rays and request that they be sent to:**


**Dr. Charles Halley**

## Gulfview Chiropractic & Wellness

**8323 US Highway 19**
**Port Richey, FL 34668**

**gulfview.chiropractic@gmail.com**

**Fax (727) 842-3524**


**Print Name of Patient:** _____

**Signature of Patient:** _____

**SSN:** XXX-XX-_____ **Date of Birth (DOB):** ____-____-_____

***FOR OFFICE USE ONLY***

**Date:** _____-_____-_____

**To:** _____

**(Doctor/Hospital)**

**Address:** _____

**City:** _____ **St:** _____ **Zip:** _____

**Phone:** (____)_____-_____ **Fax:** (____)_____-_____

# Gulfview Chiropractic and Wellness

## Insurance Verification Informaiton

Insurance Company _____

Insurance Plan Name _____

Provider Line Phone # _____ Patient's Zip Code_____

Patient Name on Insurance Card: _____

Patient DOB ____ - ____ - ____ Insurance Member ID # _____